



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### PART I: GENERAL INFORMATION

Requestor Name and Address:	MFDR Tracking #: M4-08-5695-01
REGIONAL MEDICAL CENTER ATTN SHELLI MORRISON ESQ 100 WILLOWBROOK DR ATHENS TX 75751	DWC Claim #:
	Injured Employee:
Respondent Name and Box #:	Date of Injury:
AMERICAN HOME ASSURANCE CO. Box #: 19	Employer Name:
	Insurance Carrier #:

### PART II: REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Treatment for traumatic injuries (ICD-9) code 800.0-959.50) should be reimbursed at a fair and reasonable rate of 125% of Medicare allowable."

**Amount in Dispute:** \$3,650.78

### PART III: RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The carrier stands on it's position that bill has been paid according to the medical fee guideline."

### PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
5/18/2007- 5/19/2007	150 (850-295, 900-083); W1 (647-002)	Outpatient Surgery	\$3,650.78	\$0.00
<b>Total Due:</b>				\$0.00

### PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on May 6, 2008.

- For the services involved in this dispute, the respondent reduced or denied payment with reason code:
  - 150 - PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
  - 850-295 – ABR ESIS: THE RECOMMENDED PAYMENTS ABOVE REFLECT A FAIR, REASONABLE AND CONSISTENT METHODOLOGY OR REIMBURSEMENT PURSUANT TO THE CRITERIA SET FOR IN SECTION 413.011(D) OF THE TEXAS WORKERS' COMPENSATION ACT.
  - 900-083 – ABR ESIS: THIS BILL WAS REVIEWED THROUGH THE ADVANCED BILL REVIEW PROGRAM
  - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
  - 647-002 – REIMBURSEMENT HAS BEEN CALCULATED BASED ON A PERCENTAGE OF THE CHARGES.
- Division rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, 22 TexReg 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of box 17 and 18 on the requestor's medical bill finds that the injured worker was admitted on 5/18/2007 at hour 08. Review of box 6 and box 21 finds that the injured worker was discharged on 5/19/2007 at hour 16. The submitted documentation supports that the length of stay exceeded 23 hours; the Division therefore concludes

that the services in dispute are inpatient services.

2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 886.0. The Division therefore determines that this inpatient admission is a trauma admission and shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
  - The requestor's position statement states that "Treatment for traumatic injuries (ICD-9) code 800.0-959.50) should be reimbursed at a fair and reasonable rate of 125% of Medicare allowable."
  - The requestor does not discuss or explain how payment of 125% of Medicare allowable would result in a fair and reasonable reimbursement.
  - The requestor did not submit documentation to support a specific amount or calculation of what the Medicare allowable would be for the disputed services.
  - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
  - The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
  - The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

6. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rule at 28 Texas Administrative Code §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code §413.011(a-d), §413.031 and §413.0311  
28 Texas Administrative Code §133.307, §134.1, §134.401  
Texas Government Code, Chapter 2001, Subchapter G

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

**DECISION:**

**Grayson Richardson**

**December 15, 2010**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**